FBMC

Premier Benefits Solutions
P.O. Box 1878 Tallahassee, FL 32302-1878

City of Miami Beach
Plan Year January 1, 20___ to December 31, 20___

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

You must complete this form if you wish to start or continue a before-tax Medical Expense and/or Dependent Care Flexible Spending Account.

Press hard with ballpoint pen.

Name (Please Print) Last	First	MI	Social Security #

Home Address Street	City	State	ZIP

Daytime Phone ( )	Home Phone ( )	Date of Hire	Date of Birth	Annual Salary	Work Location

ENROLLMENT STATUS: ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS ☐ NEW HIRE	Employee ID #	Effective Date (HR Use only)

E-Mail Address:

Indicate the amount you wish to pay through before-tax salary deduction by completing the sections below.
Complete the worksheets provided before deciding on the amount.
If you have questions, consult your Reference Guide or call FBMC Customer Service at 1-800-342-8017.

In Box #1, indicate the dollar amount you elect to contribute for the plan year.
In Box #2, indicate the number of regular payroll checks with deductions you expect to receive during the plan year.
In Box #3, indicate the deduction amount per paycheck. (Note: if Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding).
By signing this form, you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, or for planned retirement, or any other anticipated leave. You will receive a deduction beginning on your first pay period after you enroll.

MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT

For uninsured eligible medical expenses incurred by you, your family members, or both.
[Minimum allowable annual contribution is $130;
maximum allowable annual contribution is $5,000.]

Box #1
Total Plan Year Dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected _____

Box #3
Reduction Per Regular Paycheck _____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

TAX FILING STATUS [PLEASE CHECK ONE]: Minimum allowable annual contribution is $130.

☐ Married, filing separately [maximum - $2,500]
☐ Married, filing jointly [maximum - $5,000]
☐ Single, head of household [maximum - $5,000]

Box #1
Total Plan Year Dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected _____

Box #3
Reduction Per Regular Paycheck _____

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal and state income taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment before the end of the plan year or file an approved Change In Status Election Form with the contract administrator within 30 days of the event.
- I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this Enrollment Form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year, unless otherwise provided by law.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my Employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

Employee Signature	Date Signed

Submit your completed Enrollment Form to the City of Miami Beach, Employee Benefits

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES